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IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF SAN FRANCISCO
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PATRICIA HENLEY,
Plaintiff,
v. No. 995172
PHILIP MORRIS, INCORPORATED,
et al.,
Defendants.
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DEPOSITION OF JEFFREY AUGUST HAGEN, M.D.
January 18, 1999

Reported By:
MARY F. NELSON, CSR 3553

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BE IT REMEMBERED that, on Monday, the 18th day of January 1999, commencing at the hour of 4:00 o'clock p.m. thereof, at the LAW OFFICES OF WARTNICK, CHABER, HAROWITZ, SMITH & TIGERMAN, 101 California Street, Suite 2200, San Francisco, California 94111-5853, before me, MARY F. NELSON, Certified Shorthand Reporter No. 3553, State of California, duly authorized to administer oaths pursuant to Section 2093(b) of the California Code of Civil Procedure, personally appeared
JEFFREY AUGUST HAGEN, M.D.
called as a witness by the defendant; and the said witness, being by me first duly sworn, was thereupon examined and testified as hereinafter set forth.
LAW OFFICES OF WARTNICK, CHABER, HAROWITZ, SMITH & TIGERMAN, 101 California Street, Suite 2200, San Francisco, California 94111-5853, represented by MADELYN J. CHABER, ESQ., appeared as counsel on behalf of the plaintiff.
LAW OFFICES OF SHOOK, HARDY, BACON, LLP One Kansas City Place, 1200 Main Street, Kansas City, Missouri 64105-2118, represented by WILLIAM S. OHLEMEYER, ESQ., and GERALD V. BARRON, ESQ., as counsel on behalf of the defendant.
ALSO PRESENT: GARY WILLIAMS, Senior Analyst, at SHOOK, HARDY & BACON, LLP.

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JEFFREY AUGUST HAGEN, M.D.
having been duly sworn,
testified as follows:

EXAMINATION BY MR. OHLEMEYER
MR. OHLEMEYER: Q. Good afternoon, Dr.

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Hagen, my name is Bill Ohlemeyer and I represent Phillip Morris in a lawsuit brought by Patricia Henley. I'll try to move this along as quickly as I can. If you don't understand a question I ask will you let me know?

A. Sure.

Q. Just give me a general description of what you do on a typical day.

A. What I do on a typical day? What I do on a typical day. I practice thoracic surgery. I'm the Chief of Thoracic Surgery at LA County Medical Center and I spend most of my day operating and taking care of patients, and mixed amongst that are teaching duties at the university and research.

Q. When you say -- what is, give me a description of what thoracic surgery is.

A. Surgery of essentially the things within the chest other than the heart. I'm trained to do heart surgery but I've chosen to focus my career on noncardiac surgery of the chest.

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Q. When a doctor talks about a chest or when you see a reference to the chest is that a layman's term for thorax?

A. Yeah.

Q. What is within the chest?

A. All kinds of stuff. The heart and all the major blood vessels. The lungs and the windpipe, the trachea. Variety of fatty and lymph node-type tissues and the thymus gland and the esophagus. And there's a few other things, thoracic ducts some other things. That pretty much covers it, the common things.

Q. When you say that in a typical day, I think these were your words, I'm not trying to put words in your mouth, you operate on patients or perform operations?

A. Mm-hmm.

Q. What sort of operations are you talking about?

A. Operations on any of those organs I just mentioned.

Q. Is that something you do on a daily basis usually?

A. Probably at least three days, many times four days a week in the operating room.

Q. And how long has that been a typical week for you?

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A. About four and a half years.

Q. I take it thoracic surgery has always been your area of specialty or interest?

A. Mm-hmm, yes.

Q. In a typical week how many bronchoscopies do you perform?

A. Approximately two.

Q. And what about, I've seen the word thoracotomy?

A. Mm-hmm.

Q. What is your understanding or tell me what thoracotomy is.

A. A thoracotomy is an incision in the chest.

Q. Okay.

A. An opening in the chest is sort of a literal definition.

Q. And I assume that would include, that would

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not include bronchoscopies?
A. That's correct.
Q. It would include any other kind of biopsy that involves an incision in the chest?
A. Well, not necessarily because thoracoscopy would be another way to make a biopsy in a chest, as a mediastinoscopy. Those are all to take biopsies in the chest and it's pretty rare you do a thoracotomy just to do

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a biopsy. Usually you would do one of the other two, thoracoscopy or mediastinoscopy, obtain the biopsy. The thoracotomy is to remove what you're going at.
Q. So mediastinoscopy or thoracoscopy are lesser?
A. They are different procedures.
Q. What is an mediastinotomy?
A. Mediastinotomy, the actual full name is an anterior mediastinotomy, also goes by the name of the Chamberlain procedure. And that's actually been modified over the years since it was described by Chamberlain but it's a means of biopsying lymph nodes in the mediastinum or the hilum of the lung that are inaccessible by a cervical mediastinoscopy.
Q. Define "mediastinum" for me.
A. The mediastinum is all the contents in the middle of the chest.
Q. And these are lawyer words, not doctor words, is mediastinum geography as opposed to structure?
A. The words come from I suppose Latin or Greek but it means "stands in the middle." That's what it means. It's probably best looked at as a region of the body. But if you were to describe anatomic boundaries to it, it would be the portion of the chest that's between the pleura on either side.

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See, the lung and the other contents of each side of the hemithorax are contained within the pleural cavity. The mediastinum is not.
Q. Define the word "hilum" for me.
A. The hilum is the place where the blood vessels in the windpipe or the bronchus exit the mediastinum to enter the pleural cavity or the chest.
Q. And again is that, is that an organ or a structure or is it geography? You used a better word than I did a few minutes ago besides geography. I don't remember what it was.
MS. CHABER: Region.
THE WITNESS: It's probably best described as a region because it's not a separate organ.
MR. OHLEMEYER: Q. Is the hilum inside or outside of the lung?
A. It's a part of the lung.
Q. In what way?
A. Well, in what way? It's the origin of it, like the root of your tooth is a part of your tooth.
Q. Is it inside or outside of the pleura?
A. It is outside of the pleura. As by the way, as is the whole lung. The whole lung is outside the pleura.
Q. What about -- does the hilum contain

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parenchymal tissue?
A. I'm not sure what you're asking.

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Q. Well, define "parenchyma."
A. A parenchyma is the tissue of a given organ. So lung has parenchyma, liver has parenchyma. So I'm not sure what term you're --
Q. Is the parenchymal tissue that pertains to the lung inside the lung?
A. It is the lung. That's what makes it up. Is lung is made up of the lung parenchyma and blood vessels. Maybe I'm not understanding your question correctly.
Q. When you perform one of these procedures, like a bronchoscopy or mediastinoscopy, do you do it yourself or do you have people there, how do you do it? Just describe for me generally what happens.
A. In general terms I do them myself. There are, of course, people there with me. There's an anesthesiologist, maybe an anesthetist there, and there's usually two, sometimes three O.R. personnel there as well.
And then being at a teaching institution there's usually a resident or a fellow there with me as well. But I perform the procedures myself. With their assistance.
Q. And when you say you perform with their assistance explain for me what that means.

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A. In general terms or with respect to this particular patient?
Q. In general terms.
A. In general terms. In general terms without going into great details about the educating process of a surgeon, when I perform a procedure myself that means that the critical portions of the procedure are done by my hands. If they are not, which is sometimes the case, depending on the level of complexity of the case and the level of education of the resident, some critical portions of the procedure will be carried out by the resident or fellow.
But when I say I do the procedure myself it means my hands physically do the procedure in question.
Q. When you do those procedures I assume you create a record of them?
A. Do I create a record of them?
Q. Yeah, how --
A. Usually if I do the procedure in my own private practice, yes, I create a record that's usually the operative note. That's the record of the procedure.
Q. Okay. Now you said, you qualified it in a way that leads me to believe there are other possibilities?
A. Mm-hmm, yes, because I don't maintain private records in my office of patients that are treated under my

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supervision at the county hospital. The county hospital keeps those records.
Q. And who creates those records that the county hospital keeps?
A. The records are created usually by the senior-most resident or fellow involved in the case.
Q. And what is the purpose of creating the record, whether you do it or whether someone else does it?
A. To document what happened during the course of the operation.
Q. When somebody else creates the record of a procedure that you're involved in do you read it and review it?

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A. Yes. Normally.
Q. Are you required, do you have to sign it?
A. Normally they are sent to me for signature.
Q. Is there any significant -- or what is the significance of your signature being on a medical record?
A. I think you'd have to ask the medical record people that.
Q. What does it mean to you when you sign a record?
A. Well, if I sign it that means I reviewed it. That's what it means. Why it's required that I sign it is a mystery to me because I didn't create it. But there must

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be some regulatory thing with a Joint Commission on Accreditation of Hospitals and the like.
Q. What, you know, in your practice what is the, what is the the point of creating that operative note? I mean why do you do it?
A. The reason I do it is -- well, there are several reasons. The first reason is because it's a requirement that an operative record be completed for any patient who is operated on in any hospital. The second reason is because it's a convenient way of relaying information with respect to what was found and what was done in the operation to other physicians that might be involved in the case. And the third reason is it provides information to look back upon when questions arise in the future as to exactly what was done.
Q. How, and that's -- that really leads me to my next question. How much of an independent recollection do you have of people with, for whom you perform these procedures without reference to the records?
A. It depends on how long ago it was. And whether there was anything unusual or different about the case. Just like anyone. You remember things that are unusual.
Q. Do you have, aside from reference to medical records that either you created or that others created, do

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you have an independent recollection of a patient named Patricia Henley?
A. Yes, I do.
Q. And tell me what it is that you independently remember about Mrs. Henley or Ms. Henley?
A. Do you want me to go through her whole history?
MS. CHABER: Vague and ambiguous.
MR. OHLEMEYER: Q. What I'd like you to do is tell me what you remember about her without reference to medical records. What would you remember about her if you didn't have any of your records in front of you and you hadn't reviewed them today?
A. What I remembered of her is she was a patient that I was asked to see by a physician who commonly refers patients to my practice, Dr. Smith, and he asked if I could assist in her care because she was uninsured and he knew that I as Chief of Thoracic Surgery at the county hospital would likely be able to get her into the system, if you will, get her taken care of.
And that I saw her in the office shortly after that conversation, reviewed her films and her history, and came to the conclusion that she had an unresectable cancer of the lung that needed to be diagnosed

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and staged. So I made arrangements with the house staff on
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the service at LA County Hospital for her to have the procedure that she ultimately had.
Q. Am I correct you first saw Ms. Henley probably about a year ago, right, January of '98?
A. That's, I believe that's correct. It's on my note.
Q. When did you first review any of either your or other's records pertaining to Ms. Henley after you had discharged her from your care?
A. After I discharged her from my care. Approximately a month ago.
Q. And what was the occasion by which, for which you reviewed those records?
A. At the request of her attorneys.
Q. And what was it that they asked you to do?
A. I don't honestly remember specifically what they asked.
Q. What did you do?
A. Well, in general I was asked if I would, if I had any recollection of her, and that if I, some general descriptions of the action, and would I be willing to review the records with respect to her care largely.
Q. At that time did you have recollection of the patient?
A. Sure.
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Q. What did you recall about her at that time?
A. What I just told you before.
Q. And what general description, was it a general description of her care or a general description of her records that you were asked to provide?
A. As I recall, and I don't remember the date of this, but as I recall it was, I was told that there was a question, or that the -- excuse me, that the diagnosis that we had rendered was being questioned. And that's what I was being, my understanding was I was being asked to review the records with respect to the diagnosis she was given.
Q. What was the diagnosis -- let me ask you two questions. I'll ask them backward. When you say "we rendered," who is the "we"?
A. There are a number of physicians involved in her care. Pathologists, oncologists, radiologists, all of whom saw her while she was there.
Q. Do you know who those people were specifically?
A. I don't know their names, no.
Q. Do you know who among them specifically rendered a diagnosis as opposed to -- well, strike that.
Do you know who specifically among that group of people rendered a diagnosis with respect to Ms. Henley's cancer?
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A. I don't know their names. But those names are available in her medical records from County on the consultation from oncology as well as the pathology report.
Q. When you say any of these people rendered a diagnosis, by that do you mean it was something they recorded in their records?
A. Mm-hmm.
Q. How many of those people actually rendered a diagnosis as opposed to repeated the diagnosis of another

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doctor?
A. I don't have any way to know that.
Q. Does that occur in medical records at times?
A. It can.
Q. Is there any way to look at the records and determine who actually rendered a specific diagnosis in this case or other cases?
A. You mean as opposed to repeating a diagnosis?
Q. Correct.
A. I don't think there's any way to know that from that record. Other than to ask a person what was in their mind when they wrote down a diagnosis on a piece of paper whether they were simply repeating it or had independently come to the same conclusion.
Q. Just so I'm clear then, leaving aside for the moment, you're not sure who if anyone involved in Ms.

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Henley's treatment independently came to a conclusion about her cancer as opposed to repeated or recorded the diagnosis of another doctor?
A. I'm not sure who if anybody did or did not arrive at the same diagnosis independently.
Q. Okay. Now you said that, you said that at the time you saw Ms. -- you saw Ms. Henley in your office?
A. That's correct.
Q. And what was the -- explain that to me. How did that come about?
A. Dr. Smith asked me if I would see this patient. And he mentioned to me that she had no insurance, she had been referred to the City of Hope and declined for that amongst other reasons, and was there some way that I could help him to get this patient taken care of. The simplest solution would have been to say yes, tell her to go to County Hospital and we'll take care of her. But it is time consuming and difficult for patients who are unfamiliar with the County Hospital system to get to where they need to go.
So I decided that the most efficient way for her to get taken care of would be for her to see me in the office so I could triage her, if you will, and send her onto the appropriate place in the county system.
Q. At the time you saw her what information did

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you have in front of you, do you know, or have available to you? Let me --
A. As I recall it was just the Cat scan. It may be just a plain chest x-ray.
Q. And I'm correct what you did after you saw her was dictate a letter to Dr. Smith to summarize her history as you knew it for your records?
A. Yes.
Q. Your letter of January 26, 1998?
A. That's correct.
Q. Did you ever create or dictate another summary like this with respect to Ms. Henley at that point in time?
A. No. I dictate one note that serves both purposes, if you will, communicating with the patient and referred the patient, and maintains the important information in my hospital -- excuse me, in my office chart.
Q. Now it says here that you reviewed her x-ray and CT scans. Would that have been the report from the

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imaging services?
A. No, I don't believe I actually reviewed the report. I rarely do. I looked at the films.
Q. Okay, you looked at the films. So I understand it, you actually looked at the x-ray and CT
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scans and recorded your impressions in this letter to Dr. Smith?
A. That's correct.
Q. Did you have any of Dr. Smith's records in front of you at the time?
A. I don't recall whether I did or not.
Q. Do you recall whether Dr. Smith took a history and physical of Ms. Henley?
A. Do I recall if he did or not?
Q. That's a bad question.
A. It's hard to know whether he did or not.
Q. Did you have the record of Dr. Smith's consultation from either December 18th or January 6th?
A. Generally speaking when I review outside medical records it is noted in the note, for instance if the referring physician sends me notes there will be some statement to the effect that I also reviewed the records which you so kindly provided, etc. And as I recall there is no such statement in that note, which would lead me to conclude I likely had no other records.
Q. Was any other doctor present with you when you examined Ms. Henley or talked with her?
A. No.
Q. When you say you're dealing with an unresectable disease what does that mean?
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A. Well, at the time that she was seen it was, it was my impression that she had a cancer of the lung that was technically not resectable on the basis of her Cat scan that I reviewed. And that was largely based on the fact that this thing encompassed or encroached upon both the left main bronchus and nearly obstructed her pulmonary artery. And those are the two technical things, just from a purely technical standpoint of can the tumor come out, that led me to believe that we were dealing with an unresectable lung cancer.
Q. The main stem bronchus and the pulmonary artery extend outside the lung?
MS. CHABER: Vague and ambiguous.
MR. OHLEMEYER: Q. Don't they?
A. They also extend inside the lung.
Q. Am I correct, Doctor, there is no impression described in this January 26 letter that Ms. Henley has a cancer of the lung?
A. I'd have to look back at the notes to say for sure.
Q. You recommended that she undergo --
MS. CHABER: Do you want to give it to him? He just said he'd have to look at it to answer your question.
MR. OHLEMEYER: Q. Well, let me read, I have
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no problem --
MS. CHABER: There's one coming down.
MR. OHLEMEYER: Q. Let me hand you, Doctor, what appears to be your letter of January 26, 1998 to Dr. Smith. And the question that I think is pending is there's

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no description of a cancer in the lung?
A. Those exact words are not used in there, no.
Q. Now you recommended that Ms. Henley undergo something called a bronchoscopy, right?
A. Mm-hmm, that's correct.
Q. And as I understand it -- well, strike that. Do you know who performed the bronchoscopy on Ms. Henley? Let me rephrase the question. Can you tell by looking at the operative report who physically performed the bronchoscopy?
A. You can't tell by the operative note, no.
Q. Am I correct that the report of operation suggests there was a surgeon named Rodney Mason involved?
A. That's correct.
Q. Who is Rodney Mason?
A. He was a fellow on the service at the County Hospital at the time.
Q. And you're described as the assistant, correct?
A. That's correct.

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Q. Does that suggest or indicate to you that Dr. Mason did the bronchoscopy with your assistance?
A. No, it doesn't.
Q. Why not?
A. Because that's the way all the procedures performed at the County Hospital are recorded.
Q. So it's your testimony that you physically operated the machinery?
A. Actually both of us did. Typically on a bronchoscopy what is done at the County Hospital is that the bronchoscopy is done by the fellow who then describes for me what they see or what they found, and then I do the bronchoscopy myself to confirm that. The reason it's done in that order rather than opposite, of course, is because my observations would bias their observations and it would be less of a teaching experience with them.
Q. Exactly, unless you had a resident like some of my associates who don't care what my opinion is.
A. That's the way bronchoscopy is taught. There's another way it's done at the university hospital and in many private hospitals because they have the equipment to do so and it's done with video so everybody does it at the same time but it is not present at the County Hospital.
Q. You reviewed the report of operation, right?

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A. That's correct.
Q. And as I understand it the procedure would have been for Dr. Mason to perform the procedure, to describe his observations to you, for you to have a look yourself, assure yourself that you agree with the doctor's observations and then who, I presume somebody would then dictate --
A. That's correct.
Q. -- a report?
A. That's correct.
Q. And would that have been you or Dr. Mason?
A. That would be Dr. Mason which is why his name appears as the surgeon.
Q. And your name appears at the bottom on a signature line?
A. That's correct.

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Q. And I assume you review the report and so long as it's consistent with what happened you sign off on it?
A. That's correct.
Q. Why did you do -- strike that. Who made the decision to performed the mediastinoscopy after the bronchoscopy?
A. I did.
Q. For what reason?

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A. The goal of operating on Ms. Henley was to establish a tissue diagnosis. As I mentioned, based on her Cat scan findings it was my impression that she had an unresectable cancer, and the goal of the procedure was to establish a diagnosis and to stage the disease. The bronchoscopy is performed because it's the least invasive of the two of those procedures, and had we, for example, seen obvious tumor in the airway, biopsied it and sent it for frozen section and got a diagnosis of small cell cancer we could have spared her the mediastinoscopy. But there not being any endobronchial lesions present, we proceeded with the next step with the goal of establishing the tissue diagnosis and in this case simultaneously staging the patient.
Q. Am I correct there is a difference between impression and a diagnosis?
MS. CHABER: Vague and ambiguous.
THE WITNESS: I'm not sure what you mean by that.
MR. OHLEMEYER: Q. You used the word "impression" and then you use the word "tissue diagnosis." I assume they are two different things?
A. A tissue diagnosis is a specific type of diagnosis. A clinical diagnosis is largely the same thing as an impression.

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Q. In a cancer case, though, don't you prefer or almost always try to obtain a tissue diagnosis?
A. Of cell type, yes.
Q. Because that is information somebody needs to determine a course of treatment for the patient?
A. The cell type is needed, yes.
Q. And the tissue diagnosis is something rendered by the pathologist who reviews the specimen?
A. The pathologist who reviews the specimen describes what is seen under the microscope, assigns that to a histologic type of cancer, and gives that information back to the clinician. For instance, the pathologist has no way of knowing of whether I submit a piece of tissue labeled from one site of the body when it actually came from another. The pathologist has no way of knowing that. All they can describe what they've seen the type of tumor present, and the actual overall diagnosis that you hang on the patient comes largely from the clinical information about where that biopsy was taken from. And the pathologist tells you what type of, type. For instance, cancer of the lung, cancer of the esophagus, etc.
Q. If there is some other sort of tissue attached to the specimen the pathologist might have some idea of where or what type of organ the specimen comes from?

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A. You mean if there's -- I don't understand

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what you mean.
Q. Well, I assume if, you know, if -- well, I shouldn't assume. I'm not trying to quibble with you, but I take it you would agree typically when a pathologist looks under the microscope at something suspected of being a tumor he or she can't discern the location of the body that specimen came from without any more information than what they are looking at?
A. That's often the case?
Q. I assume there may be things attached to that specimen that may give them some clues?
A. That's correct.
Q. Do you know whether in this case whether there was anything attached to the pathology specimen besides tumor?
A. There's none described in the pathology report.
Q. And am I correct, Doctor, that in this case the biopsy specimen, tissue specimen came from outside the lung?
A. The biopsy specimen came from outside of the lung tissue itself, yes.
Q. And with respect to bronchoscopy isn't it -- well, strike that. Typically if you have a cancer that

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starts growing in the lung -- well, let me back up. When you find a tumor in the lung how do you know whether it started growing there or started somewhere else and spread to the lung?
A. There are times when that's a very difficult thing to determine. How that decision is made is on the basis of a number of observations that lead to that clinical diagnosis. For instance, the lack of known disease elsewhere would be a strong indicator that it arose in the lung rather than somewhere else. The location within the lung to some extent gives you that information as well. Whether the patient has a single pulmonary lesion or multiple pulmonary lesions or there's another factor that is helpful for differentiating metastatic lesions to the lung and lung primary tumors.
Q. Am I correct that the lung is a site where cancer that starts in other parts of the body often spreads?
A. It commonly does, yes.
Q. Do you know how frequently cancer that starts in other parts of the body spreads to the lung?
A. I'm not -- I'd have to say I don't know specific numbers.
Q. When you have a patient with a cancer that starts in the lung, and I use the word "primary to the

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lung"?
A. Mm-hmm.
Q. As opposed to one that starts somewhere else and spreads to the lung, how often does a bronchoscopy demonstrate or detect the tumor?
MS. CHABER: It's vague and ambiguous.
THE WITNESS: The answer to that question depends on I guess the appearance of the x-ray. That's the way I look at it. If the patient has a lesion visible in in the x-ray, for instance in the periphery of the lung, the bronchoscopy would be unlikely to yield a diagnosis. If the mass is in the hilar area it's quite common the

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bronchoscopy does give a diagnosis.
MR. OHLEMEYER: Q. I guess a more simple question would be in patients who you determine to have primary lung cancer how often can you vision that tumor on x-ray?
A. Most of the time.
Q. What about on CT scan?
A. Most of the time.
Q. In patients -- I take it you've had the occasion to diagnosis small cell cancer primary to the lung in patients in the past?
A. Yes, yes.
Q. How often do you, how often does a

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bronchoscopy provide tissue for the diagnosis of small cell lung cancer in your experience?
A. In my experience -- well, let me just preface that or maybe give you a little better understanding of that. When a patient has a bronchoscopy, which is more commonly done in medicine by a pulmonary medicine physician than a surgeon, if they diagnose small cell lung cancer I will likely never see that patient. So that the patients that I do bronchoscopy on have already gone through that filter in most cases. Having said that, then it's uncommon for me to make a diagnosis of small cell cancer by bronchoscopy largely for those reasons.
Q. And I take it it's because as a surgeon you don't do a lot of resections on small cell carcinoma of the lung, right?
A. That's correct. As a matter of fact, the only time in which it would be done is on a patient who has a negative bronchoscopy because the tumor is out in the periphery.
Q. Now how, do you know how often in general, I understand your situation is a little unique, leave your situation out of it, how often in general does bronchoscopy provide a tissue diagnosis of small cell carcinoma of the lung, that is primary to the lung?
A. I don't know the answer to that. I don't

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know that it's been studied.
Q. Have you reviewed any medical texts or treatises that discussed the issue?
A. Of how often a bronchoscopy is positive, no. I'm aware of how many of them are centrally located but that's a different question.
Q. How often is a sputum cytology positive in a cancer that begins or is primary to the lung?
MS. CHABER: Vague and ambiguous.
THE WITNESS: Depends on cell type and location of the tumor.
MR. OHLEMEYER: Q. How often is it positive in small cell carcinoma primary to the lung?
A. Depends on location.
Q. And describe for me the relative differences.
A. The majority of patients with small cell cancer arising in the periphery of the lung will have negative cytologies. Most patients when specimens are properly collected who have central small cell cancers would likely have a positive cytology. But the exact numbers I can't quote.
Q. Is small cell carcinoma of the lung typically present centrally or peripherally?

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A. Typically it's a central tumor.
Q. Am I correct that with respect to the
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bronchoscopy that was performed there were no obvious endobronchial lesions?
A. That's correct.
Q. Which means no tumors inside the bronchus, right?
A. That's correct.
Q. And the rest of the bronchial tube revealed no abnormal lesions, right?
A. As far as the bronchoscope can be taken in the bronchial tubes. The bronchial tubes, strictly speaking, would extend way into the periphery of the lung where the bronchoscope can't go. Within say the second or third order of the bronchus there were no lesions identified.
Q. Am I correct there was also no compression or narrowing of bronchus observed during the bronchoscopy?
A. I don't recall whether there was or not.
Q. If there was would you expect it to be described in the report?
A. Typically.
Q. And there's a description of mild inflammation of the left upper lobe bronchus?
A. Yes.
Q. What are some of the things that can cause that type of inflammation at that location?
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A. There's a lot of them. Trauma, infection, any other cause of inflammation, in some cases submucosal or beneath the lining. Tumor growth can give a similar appearance.
Q. Also things like chronic bronchitis?
A. It could. That tends to be bilateral and diffuse, however.
Q. Of course, but the bronchoscopy was only done on the left --
A. No, that's specifically why the statement the remainder of the tracheal tree was not remarkable.
Q. Am I correct that submucosal mounding is something often seen within patients with small cell carcinoma of the lung?
A. It can be seen, yes.
Q. And it's something you can observe on the bronchoscope?
A. Yes.
Q. And if you observe it typically you can do what, a punch biopsy at that point?
A. You can do a biopsy of that, yeah.
Q. Or even a brushing or washing?
A. If it's truly submucosal brushing and washing is not going to help you. You have to do a deep biopsy getting into the, hoping to get into the mucosa or
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submucosa, or a needle biopsy or a transbronchial biopsy to get to that tissue.
Q. Now in this case there was nothing about this inflammation of the left upper lobe bronchus that caused you or Dr. Mason to do a brushing, a washing, a punch biopsy or a post-thoracic needle biopsy?
A. That's not true. The reason those were not done is all of those rely on cytology for diagnosis and the

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goal of operating on this woman was to leave the operating room that day with a tissue diagnosis and stage in hand.
If you take washing, for instance, they have to be sent down and spun, they have to be stained and in many circumstances that's something that is not available on a stat or urgent basis. It's something, for instance, a pulmonologist in their office would routinely do because all he has to do is collect the specimen and send it out and have the patient come back in a week when the results were available. But when we are in the operating room a washing doesn't do us any good.
Q. You're going to do something more invasive and more reliable anyway?
A. That's correct.
Q. I'm not suggesting that you should have done such a thing. I'm just asking whether it was done and what you might have expected to find if you had done it.

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A. Yeah. Well, you didn't ask me that question but I'd be happy to answer that one.
Q. Well, what you did then was conclude the bronchoscopy, right?
A. That's correct.
Q. Without obtaining tissue for diagnosis?
A. That's correct.
Q. And proceeded to the mediastinoscopy?
A. Mediastinotomy. It's frequently in the records referred to as a mediastinoscopy but it was an anterior mediatinotomy. Or a Chamberlain procedure.
Q. And a record of that procedure was created, right?
A. That's correct.
Q. And that --
A. It's part of the same record.
Q. The dictation is part of the same record?
A. That's correct.
Q. There's also a second part of that dictation, right?
A. Not created by us. There would be a variety of things with respect to anesthesia and nursing that may be what you're looking at.
Q. Let me hand you and ask if this is your signature on this record of operation dated 2/4/98?

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A. Yes, this is what is called the green sheet at the county because it's a green piece of paper. It's a form filled out by the nursing staff that documents all the people present during the course of the procedure, and it, you know, includes a variety of other things, and the surgeon is asked, the surgeon present for the operation is, I don't know, probably "required" is a better term, to sign the form as documentation that they were actually present. That document is somewhat unique to the County Hospital because in private hospitals it's rarely if ever in question whether the surgeon was in the room when the operation occurred but it does come up from time to time at the County Hospital, being a teaching facility.
Q. You don't sign these in blank, do you?
A. No, it's all filled out by the nurse.
Q. And you review it?
A. And I'm asked to sign it as evidence -- I'm not signing as evidence of the accuracy of the document. I'm signing it as evidence of having being present

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physically for the operation.
Q. Are you saying there's something inaccurate in the document?
A. No, I'm not saying that. I'm saying my signature doesn't make any representation of whether it's accurate or inaccurate.

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Q. Well, having said that you're not in the business -- I don't mean to be facetious, you don't care to see inaccurate medical records created, do you?
A. There are things on this form, for instance the time that the patient is taken to the PAR, the recovery room, the time that the procedure is ended, which are not on the form when I sign it. So there is no way that I can verify the authenticity of all of the things on the document which is what you're asking me. My signature simply denotes the signature of the attending surgeon present. It doesn't say anything about this piece of paper other than I was present for the procedure.
Q. Is there any way you can tell us how much was on this document at the time you signed it?
A. There's no way to know it.
Q. Do you know if there was any information on this document at the time you signed it?
A. The majority of the information would be there at the time I signed it because there is a lot of stuff on there that is timed.
Q. Would the preoperative and postoperative diagnosis be on there at the time you signed it?
A. Yes.
Q. What about the primary procedure?
A. Yes.

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Q. Secondary procedure?
A. Yes.
MS. CHABER: Can I see that for a minute?
MR. OHLEMEYER: Sure.
Q. Do you recall, Dr. Hagen, whether it was you or Dr. Mason who obtained the tissue during the mediastinotomy that was submitted to the pathologist?
A. My recollection is that I did.
Q. And why is it that you recall doing that?
A. Because of the location of the tumor and because the tumor was wrapped around the pulmonary artery, and since I am the physician responsible for the outcome of the procedure, when delicate things like that are done I do them.
Q. That makes sense. That makes me feel --
MS. CHABER: A little more like you'd end up in a County Hospital. Somehow I doubt that.
THE WITNESS: You might if you end up in a car accident in Los Angeles.
MR. OHLEMEYER: Q. The portion of the report of operation that describes that part of the procedure in detail would be your dictation?
A. No, it would be reflected in the dictation done by the resident or fellow.
Q. Again you would review it?

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A. I would review all the records, the operative records that are sent to me. Not all records at the County Hospital, for that matter any hospital, always make it to where they are supposed to. And so -- but the records that

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come I review and sign them.
It's important I think also to understand that when there is some particularly unusual or important details, particularly earlier in the course of a resident's training, it's very common for me to discuss with the resident you ought to make a special note of such and such in the operative record. That doesn't mean I create a duplicate record.
Q. During the bronchoscopy did you or Dr. Mason view the left lower lobe of the lung?
A. Are you asking if I viewed the left lower lobe bronchus? It's a little bit different than the lobe itself.
Q. In what way?
A. The lobe is the entirety of the lower portion of the lung. It's not possible to view the entirety of the lower lobe of the lung with a bronchoscope. You can only view the inside of the bronchus and then only usually to what is called the segmental level.
Q. How close does that get to the left lower lobe?

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A. Well, it's a part of the lobe.
Q. Do you know whether bronchitis can produce hemoptysis?
A. It can.
Q. Do you know whether current or recent bronchial infections can create mild cases of hemoptysis?
A. They can.
Q. And I think I may have asked you this but so I'm clear, can they also create bronchial inflammation?
A. They can.
Q. Now do you know -- well, strike that. In fact you note in your operative report that Ms. Henley recently had pneumonia; is that correct?
A. No, I said she was recently diagnosed with pneumonia which is a very, very common thing in people who present with lung cancer. Probably three quarters of patients I operate with lung cancer have recently been given a diagnosis of pneumonia, usually by an emergency room physician or a physician who sees the patient in the office, does not have an x-ray available. The patient complains of a cough with a diagnosis of in quotes "pneumonia."
Q. I think what you're saying, you see the diagnosis of pneumonia in association with lung cancer often but that doesn't mean it's actually correct?

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A. That the patient never had pneumonia. In fact we see patients who are treated repeatedly, two or three treatments of antibiotics until they are referred to a specialist who arrives at the correct diagnosis. And I don't believe she ever had pneumonia.
Q. Is sputum you cytology something you are involved in as a surgeon or is that something that the pulmonologists or the other doctors --
A. There are times when I'll order a sputum cytology but they are relatively uncommon because my job is not to establish a tissue diagnosis. Most of the patients I see with a lung cancer can under appropriate circumstances be operated. So my approach to the patient, my management is to determine both the diagnosis and the stage, and a sputum cytology won't do that for you. If

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it's done we try and track down the results for obvious reasons. But it's rarely a big, it rarely has a big impact on how I will treat the patient once they have made it to that point in the system.

Q. It's something done upstream of you?

A. It tends to be done early on.

Q. And when you say you track the results down for obvious reasons?

A. There are circumstances under which a sputum cytology might keep you from having to do any procedure on

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the patient, at least from a diagnostic standpoint. For instance, if a patient shows up with a tumor in their lung by x-ray but the real reason they presented is because they had a seizure because they had a metastasis to the brain. If you sent that patient out and they get a sputum cytology, they don't need any procedures. They have a cancer that has metastasized to the brain. They have already been staged by the imaging study.

She needed a biopsy of the tissue in the hilum of her lung to decide both diagnosis and stage in her case.

Q. How often do patients with primary small cell carcinoma of the lung present with metastases at the time of diagnosis?

MS. CHABER: Vague and ambiguous.

THE WITNESS: System metastases or metastases to the lymph nodes?

MR. OHLEMEYER: Q. Metastases that can be demonstrated either by bone scan, brain scan, MRI, CT scan?

A. Those are what we could call systematic metastases. I don't know the exact personally on that. That's a group of patients as a surgeon I don't see. You'd have to ask an oncologist that question.

Q. Same question with respect, the phrase I'm, I don't think it's a very precise phrase, but survival rates,

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do you deal at all or are you familiar at all with how long after diagnosis a typical patient with small cell carcinoma of the lung --

A. I'm aware of the general numbers but I'm not involved in sort of generating those, if you will. This is a subset of patients with lung cancer that by and large surgery doesn't play a prominent role. It plays a role in diagnosis and staging, but infrequently in the treatment.

Q. And do you know -- well, strike that. I take it that if I understand what you're saying that once you perform your procedures it's then the oncologist's job to determine treatment based on the available information?

A. That's correct.

Q. Back to the bronchoscopy briefly and we'll take a break. Is there, were you unable to observe any portions of the bronchial tree that you normally would expect to observe during in this procedure during this case?

A. I was able to see those areas of the bronchial tree that we wanted to.

Q. Did you note or observe any areas of obstruction or atelectasis?

A. There are were no areas of obstruction down to the level of the segmental bronchus.

Q. Which is as far as you went?

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A. Yes.
Q. Atelectasis, A-T-E-L --
A. Atelectasis.
Q. Atelectasis?
A. If nothing else we'll get a lesson in medical terminology.
Q. I was trying to spell it for the court reporter but she probably knows better than I.
A. Atelectasis is actually a radiographic finding. It's not something you could see on a bronchoscopy. It's the consequence of lack of aeration of the lung which appears on x-ray.
Q. Were there x-rays taken of Ms. Henley postoperative?
A. I'm sure there would have been.
Q. Somebody else would have done that?
A. Well, immediately postoperatively we would have obtained the film because we were in the pleural cavity so we would want to document the lung was reinflated.
Q. You want to make sure it hasn't collapsed is the layman's terms, atelectasis, right?
A. It could be atelectasis, it could be more. Because this procedure involves opening the thorax to the atmosphere so the patient could have a pneumothorax as well

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if the appropriate precautions aren't taken to get the air out.
But we always get an x-ray at some point after the operation to confirm we did what we thought we would. They can have atelectasis which is not related to the air from the outside but lack of air opening from the inside of the lung.
Q. We're talking about atelectasis, we're talking about air gets --
A. -- in the pleural space.
Q. -- pleural space, and does the radiologist look at those films or do you look at that?
A. Well, the answer is both do. The way the radiology works, however, is that they frequently read the films after the decision as to how to manage the patient is already made. In some cases some of these procedures, the radiologist looks at the film after the patient has gone home. So the clinicians are the ones who have to decide how to manage the patient on the basis of the x-rays obtained, and the reading usually comes later.
Q. Do you know whether bronchoscopy is used to evaluate the response to treatment of patients with small cell lung cancer?
A. It would be useful I suppose if there were something abnormal bronchoscopic to start with, that they

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had a tumor that was visible and they had a response for instance on x-ray and one wanted to confirm it was complete response, a bronchoscopy might be useful.
Q. Is the mediastinum a possible site of dissemination from another site other than the lung with respect to a cancer?
A. Yes.
Q. Can it be the primary site of a cancer?
A. It can be.
Q. Am I correct, there's another reference, Doctor, to a discussion of Ms. Henley at a staff conference

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of the Pulmonary Foregut, F-O-R-E-G-U-T, Service?
A. Mm-hmm.
Q. And what is the purpose of the staff conferences?
A. The purpose of the staff conference is to review all of the patients who have been operated on recently and who are going to be operated on the following week to review their diagnostic studies, discuss with the house staff the type of operation and the appropriateness of the operation, to basically supervise the management plan of the patient.
Q. And there are two signatures on this record, Dr. Yuon, Y-O-U-N?
A. Mm-hmm.

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Q. Yuon, is that right?
A. Mm-hmm.
Q. And yours. Tell us who is Dr. Yuon is.
A. One of the surgery house staff. When we get together for that meeting and the residents and the fellows are there one of them takes care of putting up the films and presenting the details of the case and dictates a note summarizing the discussion after the conference and it comes to me as chief of the service for signature.
Q. Did Dr. Yuon play any other role in the treatment of Ms. Henley?
A. You'll have to be more specific than that. He may or may not have been the person who admitted her. He's a lower-level house staff. So they track down labs, perform vena punctures, all the things that junior house staff people do for patients.
Q. When you say admitted her what do you mean by that?
A. Someone has to do the admission physical and history on the forms required by the County Hospital.
Q. Same thing on the other end?
A. Any hospital you go into.
Q. What about the discharge?
A. It wouldn't necessarily be him, however, but one of the physicians of the team has to take care of those

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elements of paper work.
Q. Would that have been somebody who was at the staff conference?
A. Not necessarily.
Q. Do you know whether in this case it was Dr. Yuon?
A. I don't know. I don't have any knowledge as to who filled out the discharge form.
Q. Have you seen it recently?
A. No.
Q. Have you talked with any other doctors involved in the diagnosis or care of Ms. Henley after she was discharged from your care?
A. No.
Q. Have you talked with any of the witnesses that have been retain by Ms. Chaber's law firm to testify on any of the subjects?
A. No.
Q. And am I correct you intend to come to trial later this week to testify?
A. That's the intention.
MR. OHLEMEYER: Can we take a short break?

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MS. CHABER: Sure.
(Brief recess).
MR. OHLEMEYER: Doctor, just a few more
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questions. If you don't understand a question will you let me know?
A. Sure.
Q. Tell me what the Journal "Chest" is.
A. It's one of the many journals published that deals with diseases of the chest.
Q. And there's another journal call "Thorax," right?
A. Mm-hmm. Same kind of thing. Largely nonsurgical journals that deal with diseases of the chest.
Q. Do you ever read journals like "Thorax" and "Chest"?
A. I don't subscribe to them regularly. I read them when appropriate.
Q. Have you done any reading or any -- research isn't the right word, but any reading in preparation for your testimony today or for trial later this week?
A. No, I wasn't. It was my understanding that I was largely here to discuss what was done to and for Ms. Henley, not as an expert. And I think there's plenty of other people lined up to give opinions regarding the literature and expert testimony.
Q. I don't think there's a person in the room who would disagree with you on that. Let me ask you a couple questions. You said something earlier and I thought
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I wrote it down, about your recollection of this case or Ms. Henley. Is there anything any other memory you have of Ms. Henley or your role in her care that we really haven't discussed in general or specific terms today?
MS. CHABER: Vague and ambiguous.
THE WITNESS: I'm sure there are things that I remember about her that we haven't discussed. I'm not sure if there are any that are particularly important.
MR. OHLEMEYER: Q. That's fair. That's basically what I was trying to ask you. In the, in the report, what we referred to as the report of operation there's a description of the mediastinotomy that you told us you performed. I want to ask you if you have, I mean if you can tell me with any good or clear or precise recollection exactly where in the mediastinum you took the tissue that was submitted for the pathologist to review?
A. Yeah, I know quite well where. I remember quite well where. The easiest thing would be to describe it on the films.
Q. Tell me where is it you remember?
A. Because it's an area of this mass that is, I guess the best way to put it, is far from the major vascular structures as I thought was likely to give us the diagnosis needed. Obviously if I took a biopsy from the patient's left leg I wouldn't get the diagnosis. I'd stay
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away from the vessels but I wouldn't get the diagnosis. I had to balance the possibility because this tumor is well documented to be adjacent to the aorta encompassing the pulmonary artery, etc., I thought it would be best as I mentioned before that I did it, and that's where I took the biopsy.
Q. Okay. And I'm happy to have you do that for

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me but can you describe it for me, though, in descriptive terms before you show me?
A. Yeah.
Q. Do that for me.
A. From top to bottom, approximately in the center of the mass. Now just thinking from top to bottom, not from front to back.
Q. I understand.
A. And from front to back at the front. Now the mass isn't perfectly circular you but roughly speaking that's about where it was taken.
Q. So it would have been a biopsy or a piece of tissue from the center front of the mass?
A. Yeah. I guess that's the best way -- as I said, the best way would be to show you where it is, but descriptive terminology, at the front of the mass, approximately halfway from top to bottom.
Q. And it consisted almost purely of, for lack

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of a better word, tumor cells?
A. Well, you'd have to ask the pathologist that. But I wouldn't be surprised if that was their reading just because of the character of the tissue that was removed. It looked like tumor.
Q. Did you make any effort to avoid any other structure of the body?
A. No. There would be no reason to do that. Well, back up. There are some things that we would not want to biopsy. When you say any other tissue of the biopsy, we took great pains to avoid biopsying major vessels as I described. There are nerves in that area, there is the recurrent laryngeal nerve that could result in hoarseness. So there are specific things, but no effort was made to void tissue, biopsying tissue to clarify the issue you raised in the particular case.
Q. Why don't you tell me what your understanding is of the issue raised in this particular case?
A. I have been told that the diagnosis that this tumor arose in the lung is being questioned and that there is an expert who has been deposed who is of the opinion that this is a primary tumor of the thymus gland.
Q. How far away from the close I guess anatomical border of the hilum did this biopsy come from?
A. It's in the hilum.

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Q. And that's because --
A. The answer would be I guess zero. It's no distance from the hilum because it's in the hilum.
Q. And maybe I ought to ask you to describe the anatomical borders of the hilum.
MS. CHABER: Didn't we do that already?
THE WITNESS: I think we did that already.
MS. CHABER: We did that at the very beginning.
MR. OHLEMEYER: Q. Indulge me, Doctor. Maybe I'm using the wrong words.
A. Okay. The hilum is technically or structurally speaking the root of the lung. It's where the blood vessels and the bronchus, the windpipe to the lung exit the mediastinum and enter the lung. That's the hilum of the lung. And that's where this mass is located.
Q. Is it more precise to say the hilum period or the hilum of something?

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A. It's the hilum of the lung. The hilum means the root. For instance, the spleen has a hilum. I mean lots of organs have what is described as a hilum.
Q. Is there anything about the -- well, let me put it to you this way: Is there any information available about Ms. Henley that is inconsistent with an opinion that this tumor originated outside the lung?

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MS. CHABER: Vague and ambiguous.
THE WITNESS: Could you repeat the question?
MR. OHLEMEYER: Q. Well, let me ask it this way: Is it your opinion, Doctor, that this tumor originated in the lung?
A. That's my opinion, yes.
Q. Okay. And what evidence can you point to or describe for me that is inconsistent with an opinion that it originated outside the lung?
A. It's not exactly --
MS. CHABER: Is it answerable?
THE WITNESS: I'm not sure how that question can be answered but I'll give it a shot. I think that is an argument from silence which is always difficult to refute. For instance, I could tell you that I see in that chair an invisible cat and it's impossible for you to prove to me that it's not there, and that's what you're kind of asking me to do. Most, well, all of the, that I'm aware of, of the physicians that treated this patient, never questioned that that's what is going on. All the people who have examined her came to the same conclusion, so far as I'm aware, and the only people who haven't are people who have not examined the patient or seen any of the patient's films or done anything other than review some printed records. And so I think that the people who are

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charged with the day-to-day decision making and rendering and establishing diagnoses all agreed that that was what was going on here.
Q. Well, Doctor, do you know whether her oncologist would have likely treated her similarly whether that was a 6 cm mass that started outside the lung or whether that was a mass that somehow or at some, in some way started inside the lung?
A. You'd have to ask an oncologist whether their chemotherapy regimens would be different.
Q. Now using your cat analogy, though, tell me who touched or felt or photographed the cat. I don't mean to be facetious.
A. That's a good question and I think it's a very fair question. And let me as best I can try and explain the process from the surgeon's standpoint which I think is similar to all physicians involved in the care of lung cancer, the general approach to the disease.
Let's say that if a patient shows up with a mass in their lung, whether it's a central mass in the hilum or whether it's in the periphery. There are the two things to do. One is to diagnose the patient, and you need to stage the patient.
Now let's just as a demonstration example say the patient shows up with a small lesion in the periphery

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of their lung and I'm asked to evaluate it. They may have have done a sputum cytology and they may have done a bronchoscopy and it may have been nondiagnostic which is

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frequently the case because it's out there, not in the bronchus.

When I see the patient I will do the bronchoscopy again because of the importance that the bronchoscopy is negative and I'm reluctant to hang my representation and responsibility for the patient on someone else. And if I don't see anything on the biopsy, move on up to the next step. Let's say I biopsy something in the hilum or in a cervical mediastinoscopy and I come up with either a small cell or nonsmall cell cancer. Nobody has touched the primary tumor in the lung because it would be inappropriate to do so. It would not impact on the patient's treatment. It would answer the question for someone who poses it as an intellectual exercise or some reason after the fact. It would be inappropriate to biopsy it. Because you've already staged the patient and diagnosed them, and sticking a needle or hand or taking out by wedge resection or some other means to actually evaluate the lung itself would pose risk to the patient for no benefit.

So to answer your question, under these circumstances who felt it, no one. And no one with a

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finding of tumor in the hilum such as this, even if you saw a tumor this big in the lung, no one would have biopsied it under the circumstances. There would be no reason to do it.

Q. This is to a certain extent an intellectual exercise. It's not meant to cast aspersions on anything done in her treatment but the diagnosis, the staging and the treatment of Ms. Henley really wouldn't have changed whether that tumor started in, whether the first cell, the first cancer cell began growing outside the lung somewhere in the mediastinum or inside the lung; isn't that right?

A. I already told you you'd have to ask an oncologist whether their treatment would be different.

Q. From time to time can doctors, oncologists, pathologists and surgeons look at the same data set or set of information and facts, and based on reasonable differences of opinions come to opposite or different conclusions?

A. It depends on the data set. If you're asking can a pathologist who reviews six slides that were taken from the initial cell block come to a different but reasonable, or however you phrased it, conclusion as compared to a physician who has had both, all of the clinical information, the radiographic information, and actually felt and touched the tumor in question, I don't

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think it's fair to say that they can come to two different points of view.

Again, the pathologist can render an opinion with respect to what cells are seen, not where they came from. They have to be told where they come from unless as you I think pointed out there is some fragment of tissue attached to the biopsy that would indicate the site of origin. And it's my understanding both from the original description on the pathology and the subsequent deposition by -- I'm sorry I'm blanking on the name of the pathologist who reviewed them, but anyway, there was no other tissue that could clarify where the biopsy came from. So in the absence of that the only thing they can rely on is the information provided by the person who took the biopsy,

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where it came from. And this mass came from the hilum of the lung. It did not come from the mediastinum.
Q. You said something about deposition. I thought you hadn't -- I'm not trying to be antagonistic. But I thought you told me you hadn't reviewed anybody's deposition.
MS. CHABER: He didn't say that.
THE WITNESS: You asked me if I discussed with anybody involved with the case. I have not discussed with any of the experts.
MR. OHLEMEYER: Q. Whose depositions have

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you reviewed?
A. I've reviewed a number of the depositions that were forwarded to me by counsel. I don't remember the names off the top of my head. There's for sure Dr. Hammar, there was probably three or four others. I don't remember their names.
Q. When did you do that?
A. Over the past approximately two to three weeks.
Q. And are you doing that on her time or your time?
A. It's my understanding it's on her time.
Q. What are you charging her for that?
A. I believe the rate was $400 an hour.
Q. And how much time have you put into that already?
A. Approximately six hours.
Q. Are you being paid for your time today?
A. By you we hope.
MR. OHLEMEYER: He's a fact witness.
MS. CHABER: Treating physicians are entitled to get paid.
MR. OHLEMEYER: Q. Are you going to charge Ms. Chaber for your time in court?
A. Yes, I will.

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Q. Are you subpoenaed to testify in this case or are you appearing --
A. As far as I know I haven't been subpoenaed.
Q. Do you know a surgeon in Chicago named Bill Warren?
A. I know of him.
Q. What do you know of him?
A. I know he's a surgeon in Chicago and he's a thoracic surgeon in particular. I don't know him personally.
Q. Have you ever read or reviewed any of his published research in the area?
A. I'm sure I have.
Q. Tell me, Dr. Hagen --
(Discussion off the record).
MR. OHLEMEYER: Q. With respect to the biopsy, the tissue that was taken in the mediastinotomy, can you describe or tell me how far away from the closest surface of the bronchus or bronchi it was as they enter the lung?
A. In the range of 2 to 3 cms.
Q. And the same question with respect to the pulmonary arteries?
A. Probably a little closer to the pulmonary artery, maybe 1 1/2, 2 cms, something like that.

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Q. And what about the pulmonary vein?
A. It would be quite a ways from that.
Q. What about the pleura?
A. You would actually have to go through the pleura to get to it.
Q. Which as I understand it is what you describe in your report, right?
A. Well, not exactly. Maybe I can describe for you the relationship between the pleura and the lung because that might help you understand.
Q. Okay.
A. Developmentally when we are at the fetal stage of development there are two empty cavities in your chest called pleural cavities. They are completely lined by pleura and the lung grows as a bud from the chest, actually the neck and the chest, from the same bud that forms the esophagus and sprouts out sort of like, best way to think of it, as a cauliflower or broccoli growing out into the pleural cavities. As it does that it drags with it an investment of pleura.
If you take a big, floppy balloon and you push your hand in you have all around your hand one layer of the balloon, and outside of that the other side of the pleura is invaginated into the balloon. To get to something in the lung itself or the hilum through this
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approach you go through the pleura up front here which is described in the operative note and you're inside the pleural cavity, but everything in the pleural cavity has another coating of pleura on it. You'd have to again go through the pleura to get back outside of it, if that makes sense.
Q. That makes sense. I understand. What experience do you have with thymic carcinomas or thymomas?
A. Quite a bit actually, largely with reference to the treatment of patients with myasthenia gravis. It's a neuromuscular disorder that is currently associated with thymomas and carcinomas of the thymus gland. There are a number of physicians at UC that are recognized in this area and as a consequence I'm asked with some frequency to see patients with suspected tumors of the thymus gland.
Q. Am I correct as you get older the thymus tends to kind of --
A. Go away. Involute is the medical term.
MS. CHABER: Technical term, go away.
MR. OHLEMEYER: Q. Does it have the potential to involute in among the mediastinum?
A. It's usually identifiable still but quite small. It may not be seen on an x-ray, may not be seen even on Cat scans in some circumstances. But, for instance, as I mentioned I have in the past done quite a
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bit of coronary artery surgery and you will come about a thymus gland even in an 80- or 90-year-old individual but it's very small and atrophied and involuted.
Q. In most 50-year-old adults, it can't be demonstrated in most 50-year-old adults, can it?
A. Demonstrated how? It's physically present. If you opened their chest you would find it. But it may be difficult to visualize on imaging study.
MR. OHLEMEYER: Give me 30 seconds.
(Brief recess).

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MR. OHLEMEYER: Q. Just a couple more, and I realize I said that once.
MS. CHABER: Yeah, yeah, Bill, I want it on the record at least twice.
MR. OHLEMEYER: Q. Let me know if you don't understand a question.
When you did this mediastinotomy were you able to visualize the edges or borders of the tumor?
A. No, not in their entirety.
Q. Okay. Is that the right word I'm looking for, the margins or the --
A. Yeah. Well, I don't know what words you're looking for but I suspect that that's a reasonable, if I understand you correctly you're asking me where did the tumor start and where did it finish?

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Q. Yes.
A. Not in terms of etiology but physically it has a top, a bottom, a front, a back. Very clearly this type of approach can give you essentially no information about the posterior aspect of the mass. If you want I can show you exactly.
Q. I'm getting there.
A. To give you orientation. I mean the incision is made right here, to the left of the sternum usually over the second intercostal space, approximately what is called the external angle, and if you go in at that level that carries you to the level of the hilum. And you put the mediastinoscope in there and this gives me an opportunity to clarify to you, maybe similar to the bronchoscopy. When your does a mediastinoscopy with a trainee it's something only one person at a time can see and do because it has a hole in it about 2 cms or so in diameters. The same as the bronchoscopy, there is a back-and-forth between the resident doing it and the attending physician and so he can say, well, this is what I think it is, and you say, yeah, that's what it is.
And it's a small scope. 2 cms in diameter and 15 cms in length that goes into the incision and allows you to see that level of hilum. So you see the anterior surface and the top half. It would be difficult to see the

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bottom half and the posterior aspect.
Likewise in this particular case which is evident on the Cat scan the midline component of this mass went well into the mediastinum. Behind the airway. That's an area even if you tried to expose it surgically would be difficult to do it under circumstances with an extensive tumor like this. So, no, I can't see the medial aspect.
Q. Okay. Strike that. The better way to ask the question is could you visualize or discern the thymus?
A. Through this approach that's not possible to do because you're in the wrong body cavity.
Q. And you were going to show me on the CT scan where you took the biopsy?
A. Where the biopsy is.
Q. I appreciate that. And if you will identify what film and what window. I think that will be enough specificity for us.
A. Probably image No. 10 would be the best way to describe it.
Q. Put your finger on it for me. Okay.
A. And specifically where the biopsy was taken

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would be about here. Now, of course, it could have been a little bit here and a little bit here. But as I told you in my verbal description, there is a pulmonary artery here so I would not have gone lower than that because if I went

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lower than this level then you can see where the approach comes in.

This is the sternum. This is just to the left of the sternum so that's where I would be sticking a scope in downward like this to expose the hilar area. If I did it at this level the pulmonary artery is there, likewise this level. To avoid the risk of injury or biopsy to that in an obviously abnormal hilum I would have taken the biopsy approximately there.

Q. Am I right you're above the pulmonary artery?

A. Within a centimeter of it, but yes.

Q. And can you, do you see a thymus or residual thymus on any of these?

A. I don't know. But I can tell you where it would be. It would be up here in front of -- this is a key point, in front of these blood vessels.

Q. But on these --

A. Well, like many people in her age group a normal thymus is not visible. Having said that, a tumor of the thymus would likely be visible.

Most of the patients who are sent to me for evaluation for a thymoma, that is exactly the reason they are sent because it's unusual to see a thymus in an older person. If you see it it's assumed to be abnormal until otherwise --

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Q. Until otherwise --

A. -- proven or shown.

Q. Am I correct that a small cell carcinoma of the thymus wouldn't necessarily present itself at the location of the thymus, the original location of the thymus?

MS. CHABER: Vague and ambiguous.

THE WITNESS: I guess you'd have to ask somebody who is a pathology expert. Most tumors of the thymus as far as I'm aware arise in the thymus, hence their distinction as tumors of the thymus.

MR. OHLEMEYER: Q. Do you know when the thymus involutes, where those cells end up?

A. Well, they don't end up anywhere. They atrophy, they go away. They don't go anywhere. They go away.

Q. Long story short, to determine where you would expect to find a small cell carcinoma of the thymus, a question, a question I'd be better -- I should ask a pathologist?

A. The answer to the question, I would expect them in the location where the thymus usually is. In this particular case the mass is not in a location where the thymus is.

Q. That begs the question of whether or not that

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is where you would expect to find a small cell carcinoma of the thymus.

A. I'm sure you have experts that have or will testify to that.

MR. OHLEMEYER: That's all I have, Doctor, and if you'll let me know or send me a statement I'll have

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a check.

MS. CHABER: Why don't we do it on the basis of time?

MR. OHLEMEYER: 3:30 to 5:45, two hours, 15 minutes at $400 an hour.

MS. CHABER: I'll defer to people who do math.

MR. OHLEMEYER: And I'll give him a check before he comes to trial.

MS. CHABER: Fine.

MR. OHLEMEYER: To Jeffrey Hagen?

THE WITNESS: That's correct.

MR. OHLEMEYER: Thank you, Doctor, I appreciate it.

(Whereupon, the deposition was concluded at 5:45 p.m.).

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